Digest
Pharmacy Benefits and Regulation

INTRODUCTION

Prescription drugs are the fastest growing segment of health care spending in the United States.

In FY 03, the state of Connecticut spent approximately $719 million on pharmaceuticals or 5 percent of the state budget.

STATE PRESCRIPTION DRUG PROGRAMS

The state of Connecticut pays for some or all of the cost of prescription drugs for nearly 700,000 eligible state residents per month.

The primary populations covered by the state are recipients of medical assistance programs administered by the Department of Social Services (DSS), state employees and retirees, inmates of state correctional facilities, and patients at state-run hospitals and health care facilities.

Department of Social Services' medical assistance programs and state employee/retiree insurance programs accounted for 93 percent of total state pharmacy expenditures in FY 02.

More than a dozen state entities are involved in the state's pharmacy-related activities, including DSS, the Office of the Comptroller, the Department of Administrative Services (DAS), and the University of Connecticut Health Center. Key industry players are drug manufacturers, drug wholesalers, pharmacies, and pharmacy benefit managers (PBMs).

STATE PRESCRIPTION DRUG PURCHASES

The "cost" of a drug reflects expenses for research and testing, manufacturing, product marketing, and sales profit.

There is rarely a single "price" for a drug. The amount varies, depending on who is purchasing the product.

The state uses multiple approaches to obtain prescription drugs for program-eligible beneficiaries. Depending on the program, the state pays others for drugs dispensed by community or mail-order pharmacies, or the state buys drugs directly from wholesalers and dispenses them itself.

No central source of information exists regarding total state spending on prescription drugs.

Pharmacy expenditures by DSS totaled approximately $500 million in FY 03, an increase of 20 percent over the previous year. Prescription drug claims for state employees/retirees totaled $171 million in FY 03, an increase of 13 percent from FY 02.

CONTROLLING PRESCRIPTION DRUG COSTS

Program eligibility criteria, the scope of services covered, cost-sharing requirements, utilization management strategies, and reimbursement formulae all impact state pharmacy costs.

Connecticut state government is using a variety of approaches to curb prescription drug spending, but the strategies are not uniformly applied across all programs.

Several of the programs operated by the state have restrictions (e.g., federal rules, contract language, etc.) that limit the state's ability to contain prescription drug costs.

FINDINGS AND RECOMMENDATIONS

Program review committee recommendations seek to reduce the cost of prescription drugs paid for by the state. Some proposals involve the quantity of drugs purchased; others target the price paid.

Department of Social Services' Programs

The Department of Social Services has made significant progress, particularly in the last year, in implementing many of the pharmacy cost containment provisions mandated by the legislature. However, some require additional effort.

Preferred Drug List. The state has not implemented a preferred drug list -- a key cost containment mandate that could generate significant savings.

1. **The Department of Social Services shall convene the Pharmaceutical and Therapeutics Committee by January 1, 2004. If the committee has not met by that date, the authority to appoint the Pharmaceutical and Therapeutics Committee shall be transferred to the Drug Utilization Review Board within the Department of Social Services. The department shall report monthly in writing to the committees of cognizance over human services and appropriations and the Program Review and Investigations Committee on the status of the Pharmaceutical and Therapeutics Committee. Such reports shall begin January 1, 2004, and continue until a preferred drug list is established.**

2. **The Department of Social Services, in conjunction with the Pharmaceutical and Therapeutics Committee, shall develop a comprehensive preferred drug list for FY 05.**

The administration of the pharmacy benefit for HUSKY A and HUSKY B involves four separate managed care organizations and three separate pharmacy benefit managers, each with its own formulary. The Department of Social Services could maximize its power to negotiate supplemental rebates from drug manufacturers by developing a uniform, expanded preferred drug list common to all programs under DSS.

3. **The Department of Social Services shall carve out pharmacy benefits from the HUSKY A and HUSKY B programs and consolidate the administration of all pharmacy benefit programs within the department.**

4. **C.G.S. 17b-274e shall be amended to require DSS, in conjunction with the Pharmaceutical and Therapeutics Committee, to develop a single preferred drug list common to all DSS pharmacy programs.**

5. **DSS shall contract with an organization having expertise in negotiating supplemental rebate agreements with drug manufacturers in order to obtain supplemental rebates on behalf of the state of Connecticut once the preferred drug list is established.**

Maximum Allowable Cost. The legislature required the Department of Social Services to establish a maximum allowable cost for certain multi-source generic drugs dispensed under pharmacy programs reimbursed on a fee-for-service basis.

6. **The Department of Social Services should amend its criteria for maximum allowable cost pricing to require the availability of at least two, instead of three, suppliers of a generic product.**

Nursing Home Drug Return Program. Since its inception in 1998, the nursing home drug return program has produced overall cost savings of $1.4 million, with the greatest portion occurring in FY 03. Almost 28 percent (72 out of 260 nursing homes) have not returned any of the prescription drugs on the drug return list and thus, are not in compliance with the law. To date, no penalties have been assessed against nursing homes that have not complied with the program.

7. **C.G.S. Sec. 17b-363a shall be amended to require pharmacies providing prescription drugs to nursing home Medicaid clients to dispense prescription drugs covered by the nursing home drug return program in appropriate packaging so any unused drugs can be returned.**

8. **C.G.S. Sec. 17b-363a(g) shall be amended so that the list of drugs to be returned will include, BUT NOT BE LIMITED TO, the 50 drugs with the highest average wholesale price that meet the requirements for the program.**

9. **C.G.S. Sec. 17b-363a(f) shall be amended to lower the fine for any long-term care facility that violates or fails to comply with the program to $1,000 for each incidence of noncompliance.**

ConnPACE. The ConnPACE program provides prescription drug benefits to Connecticut's senior and disabled citizens. During the 2003 legislative sessions, pharmacy co-pays were increased to $16.25 per prescription. A two-tiered co-pay would encourage the use of generics by this population and allow recipients to benefit from the lower cost of those drugs.

10. **Under the ConnPACE program, the co-pay for generic drugs shall be $10, and the co-pay for brand name drugs shall be $16.25.**

11. The Department of Social Services should implement a mail order option for the ConnPACE program.

Nursing Home Drug Expenditures. State expenditures for prescription drugs in nursing homes totaled $80.7 million in 2002, representing about 29 percent of all pharmacy expenditures for Medicaid fee-for-service recipients. However, DSS does not specifically analyze prescription drug use in nursing homes.

12. The Department of Social Services should analyze prescription drug costs and utilization for Medicaid long-term care residents independent of expenditures for prescription drugs dispensed to program recipients in the community. As part of that analysis, the department should compare drug utilization and cost trends among nursing homes, examine generic versus brand name drug use, and evaluate practitioners' prescribing patterns. Based on the analysis, by January 1, 2005, the department shall recommend ways to reduce prescription drug costs in nursing homes to the legislative committees of cognizance for human services and appropriations.

340B Prescription Drug Pricing. Section 340B of the federal Public Health Service Act requires drug manufacturers to enter into agreements to provide outpatient drugs to covered entities, including Federally Qualified Health Centers (FQHCs), at discounted prices. Generally, these prices are at least as low as the prices paid by state Medicaid agencies, but to receive the discounted pricing, an FQHC must adhere to certain requirements

13. DSS should evaluate the results of the 340B pricing program and compare it to the reimbursement provided under its other pharmacy programs to determine if it should be extended to other geographic areas of the state.

State Employee Health Insurance

Although the health insurance program for state employees and retirees has used a single pharmacy benefit manager since July 1, 2003, the contract covering the services of the PBM had not been signed as of December 2003, nor had a date been scheduled for the contract to be signed. Performance measurers were not clearly established before commencement of the new contract period, and health insurers had already achieved several of the measures listed in the original Request for Proposals.

14. The contract between the state of Connecticut and Anthem Inc. for pharmacy benefit management services should incorporate pharmacy-related performance objectives with valid, quantifiable goals and require submission of periodic reports analyzing prescription drug usage by enrollees and the results of individual cost-saving measures.

Government workers in other states have much higher co-pays than Connecticut state employees. Unfortunately, the state's ability to change the agreement governing health insurance is limited. When contract negotiations do occur, the state should discuss changing the pharmacy benefit.

15. **The state should renegotiate the State Employees Bargaining Agent Coalition (SEBAC) agreement governing prescription drug benefits for state employees and retirees to:**

    - **increase prescription drug co-pay rates;**
    - **establish a three-tier system of co-payment; and**
    - **include an inflation adjustment for any long-term co-pay rates.**

Direct Purchase of Pharmaceuticals

No single agency is responsible for buying pharmaceuticals, monitoring wholesaler compliance with state contracts, or aggregating information about the state's purchases of drugs.

The state agencies involved in the purchase of prescription drugs have a limited understanding of how the pricing system for pharmaceuticals works and do not independently confirm the state is being billed correctly for the drugs it buys.

There is no written documentation of the discount the state currently receives under the primary pharmaceutical contract negotiated by the Department of Administrative Services.

Neither DAS nor the wholesaler who fills most of the orders for the state -- Cardinal Health -- is able to provide information about the amount of rebates the state has received in recent years, let alone what it may have been entitled to.

16. **On an ongoing basis, all state entities that purchase pharmaceuticals should verify the prices charged reflect the state's discount rate, monitor the availability and receipt of applicable rebates, and confirm the wholesaler has been paid by the required date. The commissioner of any agency with multiple facilities making prescription drug purchases should ensure all locations comply with these requirements and should investigate the possibility of coordinating purchases among two or more locations.**

17. **Annually, on or before October 15, each state agency that directly purchases pharmaceuticals shall report to OPM how much the agency spent on prescription drugs the previous fiscal year and the amount received back in rebates or credits from manufacturers, wholesalers, or any group purchasing organizations to which the state belongs. Agencies with multiple institutions purchasing drugs shall provide the information by individual location.**

18. **All state agencies that provide pharmaceuticals directly to patients should develop written policies regarding generic drug substitution and prior authorization for use within individual facilities.**

19. **All state agencies that provide pharmaceuticals directly to patients shall establish drug return programs for at least the top 50 drugs with the highest average wholesale price, with provisions comparable to the requirements specified in C.G.S. Sec. 18-81q for the existing drug return program used at correctional facilities.**

20. All state agencies that provide pharmaceuticals directly to patients should evaluate the eligibility of all patients for federally supported assistance programs and identify opportunities to use beneficial pricing formulae (e.g., 340B) to obtain pharmaceuticals.

21. All state agencies that provide pharmaceuticals directly to patients should investigate the value of purchasing larger quantities (e.g., 100 capsules versus 50 capsules) of routinely dispensed drugs.

22. On behalf of the state of Connecticut, the Department of Administrative Services should pursue membership in the Minnesota Multi-State Contracting Alliance for Pharmacy and other similar purchasing organizations to determine whether the state can obtain better prices for pharmaceuticals. The cost-benefit analysis should take into consideration timely payment discounts, volume rebates, and other credits.

23. The Department of Administrative Services and the UConn Health Center (UCHC) should continue meeting and develop a joint proposal for consolidation of the state's direct purchases of pharmaceuticals to occur on or before January 1, 2005. The proposal and a summary of the factors on which it is based should be submitted to OPM by March 31, 2004, for a review of the feasibility of the plan. At a minimum, the proposal should be based on:

- **an analysis of the range of prices the state currently pays for its most frequently used drugs;**
- **a projection of the costs and savings likely to result from consolidation;**
- **an understanding of how authority for comprehensive drug purchasing would be transferred from DAS to UCHC; and**
- **a review of alternative cost-saving strategies, including the feasibility of having additional small facilities obtain prescription drugs from local pharmacies rather than through direct purchase.**

ACCESS

Helping individuals obtain pharmacy benefits, particularly from a non-government source, assists the patients and reduces state expenses. Although the DSS website already offers a link to a group that helps people enroll in privately funded programs, additional efforts to expand awareness of these opportunities should be pursued.

24. The Department of Social Services should publicize private, low- and no-cost prescription drug assistance programs more widely. In particular, any person who applies to a state medical assistance program and is deemed ineligible should be provided with information about opportunities to obtain prescription drugs directly from manufacturers.